DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Living Health Care Nursing Home DATE SURVEY COMPLETED: April 20, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from April 18, 2023 through April 20, 2023. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 50. The survey sample size was four.	Cross refer to CMS 2567- 578/940	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed 4/20/23: F578 and F940.		

Provider's Signature Nancy Gachingiri Title DON Date 6/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY LIVING	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from April 18, 2023 through April 20, 2023. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 50. The survey sample size was four. Findings include: Abbreviations/definitions used in this report are as follows: ADL- Activities of Daily Living; ADON- Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Care Plan- outlines the plan of action that will be implemented during a patient's medical care; CNA- Certified Nursing Assistant; CPR (Cardiopulmonary resuscitation)- an emergency procedure that is done when someone's breathing and/or heartbeat has stopped in hopes of providing time for first responders to arrive; DMOST- Delaware Medical Orders for Scope of Treatment; DNAR- Do Not Attempt Resuscitation; DNH- Do Not Hospitalize; DNR - A do not resuscitate order or DNR order is	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

a medical order written by a Doctor. It instructs Health Care Providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating;
DON - Director of Nursing;
ED - Executive Director;
eMAR- electronic medication administration records;
EMS- Emergency Medical Services;
Intervention - action taken to improve a situation, especially a medical disorder;
L-liters;
LLE- left lower extremity;
LPN - Licensed Practical Nurse;
MD - Medical Director;
MDS assessment- federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;
N/C- nasal cannula;
N/O- new order;
Non-rebreather- a device used to deliver high concentration oxygen to a person who can't breathe unassisted;
O2- oxygen;
PCC (Point Click Care)- the facility's electronic health system; used for documentation of residents' records;
PCP- Primary Care Provider;
POA- Power of Attorney;
Repositioning- turning a patient from one side to another;
ROM (range of motion) - the measurement of movement around a specific joint or body part;
RN - Registered Nurse;
Saturation/sats- a measure of the amount of hemoglobin that is bound to oxygen at a given time point;

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F 000	Continued From page 2 Supine - lying face upward; Team Health- name of the medical practice that provides care in the building; VS- vital signs.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		5/16/23

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F 578	Continued From page 3 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews, review of clinical records and other documentation as indicated, it was determined that for two (R1 and R4) out of three residents reviewed for advance directives, the facility failed to complete the resident/responsible parties desired advanced directive. Findings include: which is required for the portable medical order to be valid (Title 16 Health and Safety, regulatory Provisions Concerning Public Health Chapter 25A Delaware Medical Orders for Scope of Treatment). Findings include: 1. R1's medical record revealed: 11/13/21- A verbal telephone order signed by E11 (MD) stated, "Resident is capable of understanding his/her rights." 11/14/21- R1 was admitted to the facility with diagnoses including moderate dementia. 11/16/21- A CPR-FULL code order was initiated by E11. 8/10/22- A CPR-FULL code order was discontinued by E11. A Do NOT Resuscitate-DNR/Do Not Hospitalize/Comfort Care/ Do Not	F 578	SHIPLEY COMPLAINT SURVEY PLAN OF CORRECTION COMPLIANCE DATE Shipley will be in compliance as of June 2, 2023. F-TAG PLAN OF CORRECTION REQUEST/REFUSE/DSCNTNUE TRMNT;FORMLTE ADV DIR F578 SS = D Corrective Action: " Corrective actions have been ensured by the Director of Nursing. Resident R1 has been provided the opportunity to review and complete an Advanced Directive that reflects the resident□s treatment decisions. The care plan for Resident R1has been updated to include the resident□s desired Advanced Directive decisions. Corrective actions have been ensured by the Director of Nursing for R4, has had an updated DMOST which is	

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F 578	Continued From page 4 weigh order was entered by E11. 8/16/22- The quarterly MDS assessment documented R1's BIMS score as 10 (moderate cognitive impairment). 10/3/22 7:03 PM- E12's Encounter note in the medical record documented that R1 was alert and oriented times two (alert to person and place or time, but not to both). 10/13/22- A verbal order was signed by E11 stating that R1 was admitted under hospice care. 10/14/22 - E2 (DON) and E3 (ADON, also covering for the Social Worker) obtained phone consent to complete the DMOST (Delaware Medical Orders For Scope Of Treatment) for a "Do Not resuscitate/DNAR" order from F1, R1's daughter. The form was not signed by R1 which violates Delaware State Code Title 16, Chapter 25A, 2509A(2)- "has been voluntarily signed by the patient or by another individual subscribing the patient's name in the patient's presence and at the patient's express direction, or, if the patient does not have decision-making capacity, by the patient's authorized representative." 10/15/22- The DMOST form was signed by E12 (NP) stating that R1 requested a "Do Not Resuscitate/DNAR" order. DMOST form Section E "Orders Discussed with" was not completed on the form nor was there an Encounter note from E12 in the medical record on or around the date of 10/15/22 specifying who the code status was discussed with from R1's family. 1/24/23- The quarterly MDS assessment documented R1's BIMS score as 9 (moderate	F 578	completed in its entirety, including completion of the resident/responsible parties desired advanced directive signed by the responsible party. Identification of Other Residents: " All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on Residents Rights, including the right to make treatment decisions and to have the opportunity to formulate an Advanced Directive. A 100% audit of all resident advanced directives has been completed to ensure that each resident has had the opportunity to make treatment decisions regarding their Advanced Directive. Residents without an updated Advanced Directive have been provided an opportunity to do so as a result of this audit, and no remaining concerns regarding Advanced Directives are noted for current residents. System Changes: " The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Advanced Directives (revised 12.2016). The facility policy Advanced Directives (revised 12.2016) was reviewed and found to meet professional standards. The facility system for the completion of Advanced Directives has been updated to include a review during the daily clinical review meeting of all new admissions for Advanced Directives completion, and for	

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F 578	Continued From page 5 impairment). 3/3/23- A Do NOT Resuscitate- DNR/Do Not Hospitalize/Comfort Care/ Do Not weigh order was entered by E11 (MD). 3/3/23- A verbal order signed by E11 stated, "Resident is capable of understanding his/her rights." Although the facility had a DNR documented for R1, the incomplete DMOST would not be honored outside of the facility. The facility failed to follow the advance directive as requested by the resident/responsible party. 2. Review of R4's medical record revealed: 5/31/12- Durable Power of Attorney Paperwork assigning F2 as R4's Power of Attorney was completed. 2/4/23- A verbal order signed by E11 (MD) stated that R4 was not capable of understanding his/her rights. 2/4/23- A Do Not Resuscitate order was entered into the medical record by E11. 2/6/23- E12 completed a portable DMOST form stating that R4 requested a "Do Not Resuscitate/DNAR" order. DMOST form Section E "Orders Discussed with" was completed on the form stating that a discussion was held with F2, however, neither R4 nor F2 signed anywhere on the form. There were two Nurse witnesses (unable to read signatures) who signed in Section E. This violates the Delaware State Code Title 16, Chapter 25A, 2509A (2)- "has been voluntarily	F 578	all changes/updates to Advanced Directives preferences; the Interdisciplinary Team (IDT) will verify that the Advanced Directive and DMOST has been completed correctly. The Director of Nursing or Designee will complete education for all nursing and social services staff on the requirements for Residents Rights, including the right to make treatment decisions and to have the opportunity to formulate an Advanced Directive. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of resident advanced directives will be completed by the Director of Nursing or Designee to ensure compliance with Residents Rights, including the right to make treatment decisions and to have the opportunity to formulate an Advanced Directive; the audits will ensure the presence of an Advanced Directive, the physician order that reflects the treatment choices, and the care plan for the advanced directive; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 578	Continued From page 6 signed by the patient or by another individual subscribing the patient's name in the patient's presence and at the patient's express direction, or, if the patient does not have decision-making capacity, by the patient's authorized representative." 4/20/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (Interim ED), E2 (DON) and E4 (Clinical Specialist).	F 578		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation as indicated, it was determined that the facility failed to ensure that an agency RN (E5) working as a Supervisor on the 11:00 PM to 7:00 AM shift had the proper training by the facility prior to working in that role. Findings include: Review of the facility's Staff Posting for the following two night shifts (11:00 PM to 7:00 AM) revealed that E5 was the only RN working: 2/25/23 - 2/26/23 and 4/17/23 - 4/18/23.	F 940	TRAINING REQUIREMENTS F940 SS = D Corrective Action: • Corrective actions have been ensured by the Director of Nursing. Employee E5 has now received the proper training for functioning as a supervisor in the facility. All current nursing employees who function in a supervisory role have been	5/16/23

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F 940	Continued From page 7 4/20/23 at 10:30 AM - During an interview, E5 (Agency RN) confirmed that she had been working as a Supervisor on night shift and she had not received any Supervisor training nor was she familiar with the facilities policies and procedures. 4/20/23 at 11:06 AM - During an interview, E2 (DON) confirmed that E5 (Agency RN) did not have any Supervisor training prior to working in that role on night shift. E2 provided the Surveyor with the Agency Orientation white binder entitled, "Agency Nurses Policy and Manual Folder", which had an Inservice Sign-In Sheet that lacked evidence of E5's signature that she reviewed the facility's policies and procedures. E2 also added that the Supervisors exchange a Supervisor binder during each shift change. 4/20/23 at 2:00 PM - The finding was reviewed during the Exit Conference with E1 (Interim ED), E2 (DON) and E4 (Clinical Specialist).	F 940	provided training for the nursing supervisor role. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nurses who function as a nursing supervisor, including agency staff, will receive orientation related to the requirements for shift supervision. A 100% audit of all nursing staff training has been completed to ensure that each staff member has received orientation and training consistent with their expected roles. Staff members without completed orientation or training requirements completed and on file have been provided the appropriate training as a result of this audit, and there are no remaining concerns regarding training requirements for staff, including those who function as nursing supervisors. System Changes: • The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy "On-the-Job Training" (rev. 1.2008) and "Departmental Supervision, Nursing" (revised 8.2022). The facility policies "On-the-Job Training" (rev. 1.2008) and "Departmental Supervision, Nursing" (revised 8.2022) were reviewed and found to meet professional standards. The facility system for the completion of nursing supervisor orientation has been updated to include On-the-Job training with a nursing supervisor for orientation,	

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F 940	Continued From page 8	F 940	education, and training prior to a nurse functioning in the role of a nursing supervisor; nurse supervisor training will be completed by the Director of Nursing or Designee. The Director of Nursing or Designee will also complete education for all nursing staff on the requirements for staff training and for functioning in the Nursing Supervisor role. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • An audit of a random sample of 10% of nursing staff training requirements will be completed by the Director of Nursing or Designee to ensure compliance with staff training requirements and the the requirements for their expected roles, including those functioning as nursing supervisors; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	